SOCIO-COGNITIVE CORRELATES OF DEPRESSION AMONG ADOLESCENTS

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Adolescence is an important developmental period for understanding the nature, course, and treatment of depression. It is the peak period for the emergence of depression (Hankin et al., 1998), and depressive episodes in youth frequently lead to devastating ripples across emotional and socioeconomic domains. The image of adolescence as a time of storm and stress, intense moodiness, and preoccupation with the self has permeated both professional and lay perspectives on this developmental period. The belief that significant difficulties, including depression, during adolescence represent normal development has had two major effects on research and practice: (a) Difficulties during adolescence were not considered as an important developmental variation, and (b) adolescent problems were often not treated because of the belief that the adolescent would grow out of them.

ADOLESCENT DEPRESSION

There are three approaches of adolescent depression to the assessment and classification of adolescent psychopathology: (a) depressed mood, (b) depressive syndromes, and (c) clinical depression. Each approach reflects different assumptions about the nature of psychopathology, serves different purposes, and reflects a different level of depressive phenomena (Angold, 1988; Cantwell & Baker, 1991; Kazdin, 1988; Kovacs, 1989).

Depressed Mood

Adolescents may experience periods of sadness or unhappy mood at different situations in his or her life, such as the loss of a significant relationship or failure on an important task. They may last for a brief or an extended period of time; they may be associated with many problems or no other problems. Research on depressed mood has been concerned with depression as a symptom and refers to the presence of sadness, unhappiness, or blue feelings for an unspecified period of time. Depressed mood is typically measured through adolescents' self-reports of their emotions, either through measures specifically concerned with mood (Petersen et al., 1984) or through items included in checklists of depressive symptoms (Kovacs, 1980). Sad or depressed mood is usually experienced with other negative emotions, such as fear, guilt, anger, contempt, or disgust (Watson & Kendall, 1989) and is frequently present during adolescence when any of these other negative emotions are present (Saylor et al., 1984).

Depressive Syndromes

Depression is viewed as an assemblage of emotions and behaviors/actions that have been found statistically to occur together in an interpretable pattern at a rate that exceeds chance, without implying any particular model for the nature or cause of these associated symptoms. This approach has recognized a syndrome of complaints which include both signs of anxiety and depression and is based on symptoms such as feels lonely; cries; fears doing bad things; feels the need to be perfect; feels unloved; believes others are out to get him or her; feels worthless, nervous, fearful, guilty, self-conscious, suspicious, or sad; and worries (Achenbach, 1991a, 1991b, 1991c). This syndrome has been acknowledged in reports of adolescents, their parents, and their teachers. Scores on this syndrome are strongly related (average r = .51) to seven other problem syndromes identified by this approach: withdrawn, somatic complaints, social problems, thought problems, attention problems, delinquent behavior, self-destructive, and aggressive behavior (Achenbach, 1991a).

Clinical Depression

American Psychiatric Association and **World Health Organization** are two major diagnostic models typically used to diagnose clinical depression. The American Psychiatric Association method is the one most widely used in the United States and abroad (Maser et al., 1991). It bases the diagnosis of disorders on a review of the presence, duration, and severity of sets of symptoms. American Psychiatric Association not only assumes that depression includes the presence of an recognized syndrome of associated symptoms but also assumes that these symptoms are associated with significant levels of current distress or dysfunction and with increased risk for impairment in the individual's current functioning. According to DSM V, the adolescents must have experienced five or more of the following symptoms for at least a two-week period to meet the criteria for major depressive disorder (a) depressed mood during most of the day, particularly in the morning (b) fatigue or loss of energy almost every day (c) feelings of worthlessness or guilt almost every day (d) impaired concentration, indecisiveness (e) insomnia (an inability to sleep) or hypersomnia (excessive sleeping) almost every day (f) markedly diminished interest or pleasure in almost all activities nearly every day (g) recurring thoughts of death or suicide (not just fearing death) (h) a sense of restlessness or being slowed down (i) significant weight loss or weight gain.

A key sign of depression is either depressed mood or loss of interest in activities. For a diagnosis of depression, these signs should be present most of the day either daily or nearly daily for at least two weeks. In addition, the depressive symptoms need to cause clinically significant distress or impairment. They cannot be due to the direct effects of a substance, for example, a drug or medication. Nor can they be the result of a medical condition such as hypothyroidism.

On the basis of high prevalence rate of adolescent depression or associated negative consequences with depression, researchers have sought to identify core etiological components (cognitive emotion regulation strategies, negative cognitive styles and perceived social support) that cause major depressive disorder (MDD) in late adolescents.

COGNITIVE EMOTION REGULATION STRATEGIES

Depression is a disorder of impaired emotion regulation. Research on emotion regulation, often defined as the ‘‘processes by which individuals influence which emotions they have, when they have them, and how they experience and express these emotions’’ (Gross, 1998). Sustained negative affect and a continual diminution in positive affect are the important features of a diagnosis of a major depressive episode. Indeed, theorists have recommended that depression vulnerable and non-vulnerable people do not differ primarily in their initial response to negative circumstances, other than their ability to recuperate from the ensuing negative affect (Teasdale, 1988). Individual differences in the habitual use of specific emotion-regulation strategies may play an important role in the onset and maintenance of depression. It is estimated that there are numeral factors that have an effect on emotion regulation in depression, involving essentials of effective strategies and motivation to implement them (Campbell-Sills & Barlow, 2007; Kring & Werner, 2004).

A very few literature have examined the use and effectiveness of cognitive emotion-regulation strategies in adolescent depression. The findings of these studies support the claim that more frequent use of certain strategies (e.g., expressive suppression, thought suppression, rumination, catastrophising) and less frequent use of other strategies (e.g., reappraisal, self-disclosure) are associated to levels of symptoms of depression and anxiety (Campbell-Sills et al., 2006; Garnefski & Kraaij, 2006, 2007; Gross & John, 2003). In addition, the studies suggest that impaired emotion regulation not only characterizes

currently depressed individuals, neverthless also apparent following recovery from this disorder (Ehring et al., 2008). Even though it is difficult to classify a specific emotion regulation strategy as maladaptive without taking into account the context in which the strategy is used, several studies have confirmed that the persistent use of specific strategies, primarily reappraisal and expressive suppression, is linked with positive and negative outcomes, respectively. While cognitive reappraisal involves the reinterpretation of the emotion-eliciting situation in a way that changes the emotional reaction, expressive suppression engross in inhibiting the behavioural expression of the emotion experience. Certainly, recent researches reveal that voluntary changes of the interpretation of a situation can change the intensity of an emotional reaction (Gross, 1998; Ochsner et al., 2002; Ochsner et al., 2004). Furthermore , it is notable that emotion-regulation strategies that rely less on changes in cognition, like hang-up of emotion expression, have been constantly found to be less efficient than are strategies that target cognition (Gross, 1998; Gross & Levenson, 1997). Prominently, customary use of reappraisal versus expressive suppression has been shown to be linked with the experience and expression of greater positive affect and lesser negative emotional impact, better interpersonal functioning, and expanded well-being (Gross & John, 2003).

The recognition of individual emotional regulation strategies as either adaptive or maladaptive may have important allegation for individuals currently experiencing a depressive episode. It is doubtful, however, that people rely on a single strategy to manage or cope with negative emotions; as an alternative, it may be more common to employ a combination of strategies. This thought is supported by the high inter correlations that are often found among emotional regulation strategies (Gross & John, 2003). There are four emotional regulation strategies frequently studied within depressed and dysphoric samples: ***Cognitive reappraisal, emotional suppression, ruminative reflection, and ruminative brooding.***

Cognitive reappraisal:

In this emotion regulation strategy, the individual reinterprets negative thoughts or experiences in a way that lessens the intensity of his or her negative emotional response. In comparison to

people receiving no emotional regulation instructions, people instructed to reappraise report less subjective negative affect and demonstrate reduced physical stimulation in response to negative stimuli (Ray et al., 2010). Intensified habitual use of cognitive reappraisal is also linked with strengthen positive affect, interpersonal functioning, and general wellbeing (Gross & John, 2003). It is, therefore, considered to be an adaptive emotion regulation strategy. Individuals with major depressive disorder (MDD) report less frequent use of reappraisal than remitted or never-depressed participants, suggesting that a lack of reliance on reappraisal in response to negative emotions can lead to the development of depressive symptoms and may maintain them over time (Joormann & Gotlib, 2010).

Expressive suppression:

Suppression refers to inhibiting the expression of the negative emotion. People who suppress their emotional experiences have been found to engage in negative affect, and individuals who habitually suppress their emotions demonstrate avoidance of close relationships, decreased social support, and lower levels of general well-being (Gross & John, 2003). Ehring et al., (2010) found that spontaneous use of suppression was reported more frequently among recovered depressed compared to never-depressed participants and was related to higher levels of negative affect in response to a sad mood induction.

Rumination:

Rumination, viewed as a breakdown in negative affect regulation caused by focusing on feelings and enhancing negative cognitions, predicts depressive disorders, the onset of depressive episodes and anxiety symptoms (Nolen-Hoeksema et al., 2008). Additionally, though research exists examining the relation of rumination with depression longitudinally, approximately all of this studies have focused on the onset or recurrence of depressive episodes. Research examining rumination in relation to the maintenance of depression symptoms has been largely ignored (Aldao et al., 2010). Cross-sectionally rumination has been found to relate to increased negative affect, reduced problem-solving, and deficits in inhibitory cognitive processes among depressed individuals (Donaldson & Lam, 2004; Joormann & Gotlib, 2010). Nevertheless, the construct of rumination as it has been operationalized in measures such as the Ruminative Responses Scale (RRS; Treynor

et al., 2003), may contain both maladaptive and adaptive components. In their factor analysis of the RRS, Treynor et al., (2003) found that the measure tapped two distinct dimensions of rumination: **Brooding** (negative, self-reflective, perseverative thinking) and **reflection/pondering** (self-focused, intellectual inquisitiveness). Research has constantly revealed brooding to be maladaptive. It is connected with greater depressive symptoms, negative attribution styles, and deficits in interpersonal functioning (Lo et al., 2008; Pearson et al., 2010).

In contrast, there is some evidence to suggest that **reflection** can be used as an adaptive emotion regulation strategy. Joormann et al., (2006) found that, in response to sadness, healthy controls reported relying on reflection more often than brooding, while individuals with major depressive disorder reported brooding more often than reflecting. Additionally, among participants with major depressive disorder, they found that the relation between rumination and other negative outcomes such as biased attention for dysphoric stimuli was driven by scores on the brooding subscale.

NEGATIVE COGNITIVE STYLES

According to the cognitive theories of depression, the etiology of depression can be categorized into two wide groups. The first group consists of the hopelessness theory of depression (Abramson et al., 1989) and another group involves Beck's (1967) theory of depression. Both of these theories are cognitive vulnerability– stress models that give emphasize to the particular content of cognitions that occur in response to negative life events in the etiology of depression. According to the hopelessness theory of depression, (Abramson et. al., 1989) negative cognitive styles are characterized a way of thinking about the self and the world (Hankin & Abramson, 2002). The term negative cognitive style refers to how an individual think about causes, consequences, and the implications for one's self after a negative event happened (Hankin & Abramson, 2002). The tendency to interpret causes of unpleasant events as stable (things will for all time be this way), global (this negative event have an effect on different areas of life), and internal (this occur for the reason of something about one's self) characterizes negative attributional style. Negative cognitive style include two additional elements to negative attributional style by comprising hope of another negative outcome after an unfavorable event

and negative implications for one's self as a consequences of the adverse event (e.g., because of this event something has done wrong; Hankin & Abramson, 2002). An additional concept of cognitive vulnerability employ in past research is that of negative self-schema, which refers to general negative beliefs about the self that are connected with a lesser sense of self-worth and self-efficacy (Hammen, 1988). Negative self-schema is reflected in the negative implications about one's self after a negative event, which are involved in the definition of negative cognitive style.

Alike to hopelessness theory of depression, Beck's cognitive theory is diathesis–stress theories that conceive a chain of contributory causes that interact with one another to culminate in depression (Beck, 1967, 1983). Fundamental to Beck's theory is the construct of schema. Beck defines schema as stored bodies of knowledge (mental representations of the self and previous experience) that are relatively continuing attribute of an individuals' cognitive organization. When an individual deal with a circumstances, the most appropriate schema to the situation is make active. The activation of schema therefore influences how an individual perceives, encodes, and retrieves information concerning the situation. Beck (1967, 1983) proposes that individuals with depressogenic schema confer vulnerability to depression. Beck hypothesize that depressogenic schema is distinctively structured as sets of dysfunctional attitudes such as "I am nil if a person I love doesn't like me" or "If I am unsuccessful at my work than I am a failure as a person." Such negative schemas make activate following the occurrence of negative events. The activated depressogenic schema generates a pattern of negatively biased; self-referent information processing characterized by negative errors in thinking (e.g., negatively skewed interpretations of negative life events such as overgeneralization and catastrophizing). Negative errors in thinking process increase the likelihood that people will extend the negative cognitive triad. Beck defines the negative cognitive triad as incorporates three different depressogenic cognitive patterns: negative views of the self (e.g., the belief that one is scarce, inadequate, or undeserving), negative views of the world (e.g., interpreting life experiences in terms of themes of conquer or criticism), and negative views of the future (e.g., the expectation that one's complexities will carry on in the future and there is nothing one can do to change this). According to the Beck's view the negative cognitive triad as a proximal, sufficient cause of

depression, once an individual develops the negative cognitive triad, he or she will develop depressive symptoms.

A cognitive diathesis stress model of depression, has received extensive support among adolescents (Abela, 2001; Hankin et al., 2001), and it recommend that depressogenic attributional or negative cognitive styles interact with stressful life events contributing to the emergence of a particular subtype of depression—hopelessness depression. Research has found that the interaction of depressogenic attributions and stress forecast higher levels of depressive symptoms in general and hopelessness depression symptoms precisely (Abela & Seligman, 2000). For instance, hopelessness theory is typically investigated within a diathesis-stress framework; it proposes that the interplay of a cognitive diathesis and the occurrence of stressful life events amplify the likelihood of experiencing depressive symptoms. Thus, in the absence of stress, vulnerable individuals who possess cognitive diatheses are no more likely than non vulnerable individuals to experience depressive symptomatology (Ingram & Luxton, 2005).

PERCEIVED SOCIAL SUPPORT

Depression is the frequent psychiatric problem faced by adolescents and is linked with functional impairment, suicide, and psychiatric comorbidity, as well as future academic failure, marital difficulties, unemployment, substance abuse, and legal problems (Lewinsohn et al., 1993). Because depression is so insidious, research has paying attention on identifying risk factors for this disturbance. A leading viewpoint is that deficits in social support increase the risk for depression (Monroe, 1983; Windle, 1992). It has been observed that social support has a noteworthy function so as to keep psychological health against psychological damages caused by stressful life experiences. Therefore, it is considered that social support plays an essential role in adolescents' managing problems in their development phases, shielding themselves in cases of stressful life experiences, crisis, and in their personal and social adjustments. As adolescents obtain more social support from their families, friends, and the society, they show more physical health symptoms and less psychological symptoms. The stress-buffering models (Windle, 1992) contend that social support moderate the relationship between stressful life events and depression. Deficits in perceived support have forecast future increases in depressive symptoms during adolescence (Lewinsohn et al., 1994; Sheeber et al., 1997; Slavin & Rainer, 1990; Stice

& Bearman, 2001; Windle, 1992). Some researchers have found potential effects for adolescent girls but not adolescent boys (Slavin & Rainer, 1990; Windle, 1992). Studies with adult population have been likely to find non significant relations between perceived support and persistently increase in depressive symptoms (Monroe, 1983). On the contrary, interpersonal accounts of depression hypothesize that the negative self-statements, complaints, dependency, reassurance seeking, inappropriate disclosure, and social inadequacy exhibited by depressed people promote support erosion (Coyne, 1976). Theorists have also suggested that support and depression are mutually related (Lazarus & Folkman, 1984). Depressive symptoms forecast reduce in perceived family support but not perceived peer support during late adolescence, but this result was observed only for girls (Slavin & Rainer, 1990). Sheeber et al., (1997) found that depressive symptoms did not foretell future diminish in familial social support for boys or girls. Depressive symptoms did not predict enhance in social rejection in male and female college students (Joiner & Metalsky, 1995). These researches communally propose that the relationship of depression to support erosion is more enunciate for females and for younger adolescents. When people are randomly assigned to interact with depressed or non depressed individuals, the former are constantly more rejected and less accepted (Coyne, 1976). These findings entail that depression demonstrate inconsistent relations to support erosion from family and peers but that depressed people constantly bring out refutation from strangers. This implies depression may produce the tough rejection among individuals who have not yet developed a close relation with the depressed individual.

A substantial amount of studies have investigated the relationship between depressive experiences and social support (Brown & Harris, 1978; Coyne & Downey, 1991). Facts advocate that social support eventually predicts depressive symptoms (Kendler et al., 2005; Moos et al., 1998; Stice et al., 2004). The reverse way, in which depressive symptoms erode social support, has accepted varied support (Davila et al., 1997; Moos et al., 1998; Stice et al., 2004). In combination, these results support poor social support as susceptibility to depressive symptom increases, and in some measure support a mutual effects model in which depressive symptoms signify decline in social support. In the literature, social support is also considered of as a personality constructs (Gayman et al., 2011; Steer & Beck, 1985). This personality construct proceed as a shield for negative life events (Robbins et al., 1993). People with sound mind may

need social support and encouragement from others to treat with normal day by day stressors (Robbins et al., 1993), and social support works as a shelter from these stressors or stress related like symptoms (Lee et al., 2007; Roma et al., 2010; Robbins et al., 1993). People with less social support may start to develop negative self-images and feel that they will be unable to overcome their issues (Bandura, 1977; Zeiss et al., 1979). Wei et al., (2005) found that social support works as a mediator between loneliness and depression when the individual moves away from home for the first time. This lack of social support of the parents can create stress within in the individual that needs to be compensating by peer social support. Thus it can be say that social support is a very important part of an adolescent's feelings of being loved and valued (Auerbach et al., 2011).

In the light of available literature, researchers have sought to identify core etiological components that cause major depressive disorder (MDD) in late adolescents. Therefore researcher will examine the contribution of cognitive emotion regulation strategies, negative cognitive styles and perceived social support in relation to adolescent's depression.

METHOD

PROBLEM:

To examine the intercorrelation of cognitive emotion regulation strategies, negative cognitive styles and perceived social support with magnitude of depression among late adolescents.

JUSTIFICATION OF THE STUDY

Among all mental health problems depression is one disorder that has major public health importance in terms of its prevalence, clinical manifestation, functional impairment, morbidity and economic burden. The cases of depression are increasing at an alarming rate. Depression is taking in its grip, not only adults but also children and adolescents. Apart from neurotransmitter (serotonin) fluctuations, this disorder is always linked with the maladaptive internal constitution (in terms of thought process) in adolescents. In other words, adolescent's negative cognitive styles in relation to day to day life stress, cognitive emotion regulation strategies (e.g., cognitive

reappraisal, catastrophizing, self blame, rumination etc.) and perceived social support are such components that are believed to be involved in the maintenance of the clinical symptoms in depression . In India, relatively very few studies have examined the contribution of cognitive emotion regulation strategies and negative cognitive styles in maintenance of depression in late adolescents. However, a number of researches have done on social support in adolescents but in present study the researcher will examine the contribution of perceived social support (from family, friends and a significant other), cognitive emotion regulation strategies and negative cognitive styles in developing depression in late adolescents. Apart from this, the researcher will examine the contribution of all three predictor variables in developing depression in Science and Arts students separately. A comparison will also make of magnitude of depression among Science and Arts students because different streams have important implications for developing depression in late adolescents.

OBJECTIVES:

- To study the relationship of cognitive emotion regulation strategies, negative cognitive styles and perceived social support with magnitude of depression in late adolescents.
- To study the relationship of cognitive emotion regulation strategies and perceived social support with negative cognitive styles.
- To study the relationship of cognitive emotion regulation strategies with perceived social support.
- To find out the relative contribution of cognitive emotion regulation strategies, negative cognitive styles and perceived social support in determination of magnitude of depression in late adolescents.
- To study the relationship of cognitive emotion regulation strategies, negative cognitive styles and perceived social support with magnitude of depression in Science students.
- To find out the relative contribution of cognitive emotion regulation strategies, negative cognitive styles and perceived social support in determination of magnitude of depression in Science students.
- To study the relationship of cognitive emotion regulation strategies, negative cognitive styles and perceived social support with magnitude of depression in Arts students.

- To find out the relative contribution of cognitive emotion regulation strategies, negative cognitive styles and perceived social support in determination of magnitude of depression in Arts students.
- To compare the magnitude of depression among Science and Arts students.

HYPOTHESES:

- There will be significant relationship of cognitive emotion regulation strategies, negative cognitive styles and perceived social support with magnitude of depression in late adolescents.
- There will be significant relationship of cognitive emotion regulation strategies and perceived social support with negative cognitive styles.
- There will be significant relationship of cognitive emotion regulation strategies with perceived social support.
- Relative contribution of cognitive emotion regulation strategies would be much remarkable as compared to negative cognitive style and perceived social support in determination of magnitude of depression in late adolescents.
- There will be significant relationship of cognitive emotion regulation strategies, negative cognitive styles and perceived social support with magnitude of depression in Science students.
- Relative contribution of cognitive emotion regulation strategies would be much remarkable as compared to negative cognitive style and perceived social support in determination of magnitude of depression in Science students.
- There will be significant relationship of cognitive emotion regulation strategies, negative cognitive styles and perceived social support with magnitude of depression in Arts students.
- Relative contribution of cognitive emotion regulation strategies would be much remarkable as compared to negative cognitive style and perceived social support in determination of magnitude of depression in Arts students.
- There will be significant difference in magnitude of depression among Science and Arts students.

DEFINITION OF TERMS:

Cognitive Emotion Regulation Strategies:

Cognitive emotion regulation strategies (self-blame, other-blame, rumination, catastrophizing, putting into perspective, positive refocusing, positive reappraisal, acceptance and planning) are defined as cognitive coping strategies in which the emotional responses to events causing the individual emotional aggravation.

Negative Cognitive Styles:

The term negative cognitive style refers to how a person thinks about causes, consequences, and the implications for one's self after a negative event occurs.

Perceived Social Support:

The tendency to experience negative cognitions and moods might cause individuals to perceive themselves as needing more social support (from family, friends and significant other) in order to manage their intrapersonal distress.

Depression:

Depression is an emotional state marked by great sadness and apprehension, feelings of worthlessness and guilt, withdrawal from others, loss of sleep and appetite, loss of interest and pleasure in usual activities.

SELECTION OF SAMPLE:

Sample for this study involves 300 adolescents from Science and Arts streams (150 boys and 150 girls) in the age range of 15-18 years. It will be collected from different schools and colleges of Agra and Jhansi district.

Inclusion criteria-

- Age range will be between 15-18 years.
- 150 boys and 150 girls will be included in the sample for equal gender representation.
- The sample will be included the students of only Science and Arts streams.

Exclusion criteria-

- The students who are below 15 years or above 18 years will not be included in the sample.
- The students who are from other streams except from Science and Arts will not be included in the sample.

VARIABLES:

Predictor variables - Cognitive emotion regulation strategies

Negative cognitive styles

Perceived social support

Criterion variables – Depression

TOOLS:

- **Cognitive Emotion Regulation Questionnaire (CERQ) (Garnefski, Kraaij et al., 2002).** The CERQ is a 36-item questionnaire consisting of the following nine conceptual distinct subscales, each consisting of four items and each referring to what someone thinks after the experience of threatening or stressful life events: self-blame, other-blame, rumination, catastrophizing, putting into perspective, positive refocusing, positive reappraisal, acceptance, and planning. Cognitive emotion regulation strategies were measured on a 5-point Likert scale ranging from 1 (almost never) to 5(almost always). Individual subscale scores were obtained by summing the scores belonging to the particular subscale (ranging from 4 to 20). All sub-scales have good internal consistencies ranging from .68 to.86 respectively.

- **Adolescent Cognitive Style Questionnaire (ACSQ; Hankin & Abramson, 2002).** The ACSQ assesses cognitive vulnerability including negative inferences for cause, consequence, and self. The ACSQ is composed of 12 hypothetical negative life event scenarios (a) across interpersonal and achievement domains and (b) relevant to adolescents. Items on the ACSQ range from 1 to 7, and the average response across items

within a given subscale is computed. Internal consistency reliability for the overall ACSQ with coefficient alpha of .95.

- **Multidimensional Scale of Perceived Social Support (MSPSS; Zimet, Dahlem, Zimet, & Farley, 1988).** This 12-item self-report scale measures a child or adolescent's perceived social support. Items are rated on a 7-point Likert scale, with higher scores corresponding to greater social support. Items were summed in each of these subscales to get a total score for perceived family, perceived peer and perceived significant other support. The MSPSS has demonstrated good internal and test-retest reliability, adequate construct validity, and factorial validity (Zimet et al., 1988). The test-retest reliability for the family, friends and other significant sub-scales were .85, .75 and .72. The range of coefficient alpha was .81-.93 for the family, .78-.94 for friends and .79-.98 for significant other.

- **Beck Depression Inventory - II (Beck, 1996):** The Beck Depression Inventory will be used to measure the magnitude of depression. Its second edition (BDI-II) is a self report instrument for measuring the severity of depression in adults and adolescents aged 13 years and older. The coefficient alpha of the BDI-II for the out patients was .92 and for college students .93. The test retest correlation of the test is .93, which is significant ($p<0.01$). Several different types of analysis were conducted to estimate the convergent validity of the BDI-II; the mean BDI-I and BDI-II score were 18.92 (S.D. =11.32) and 21.88 (S.D. =12.69) respectively**.**

DESIGN:

Correlational design will be used.

STATISTICAL ANALYSIS:

- Multiple regression analysis will be done to see the contribution of cognitive emotion regulation, negative cognitive styles and perceived social support with magnitude of depression.

- ‘t’ test will be used to test the hypothesis for comparison of depression among Science and Arts students.

CLINICAL IMPLICATION OF THE STUDY:

In this section, the researcher will explain how the findings of present study will help the clinicians to understand depression and its determinants.

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